BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

SHARON FLAITZ	)	
Claimant	)	
	)	
VS.	)	
	)	
CBOCS WEST, INC.	)	
Respondent	)	Docket No. 1,050,519
	)	
AND	)	
	)	
INDEMNITY INS. CO. OF NORTH AMERICA	)	
Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Respondent and its insurance carrier (respondent) requested review of the December 27, 2012, Award entered by Administrative Law Judge (ALJ) Rebecca A. Sanders. The Board heard oral argument on April 19, 2013. Scott J. Mann, of Hutchinson, Kansas, appeared for claimant. Clifford K. Stubbs, of Kansas City, Kansas, appeared for respondent.

The ALJ found claimant had a 33 percent permanent partial functional impairment to the whole body and a 73.25 percent work disability.

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

Respondent requests review of the ALJ's conclusion that claimant suffered injury to her neck and/or cervical spine as a result of her work-related injury. Respondent argues claimant should only be entitled to an award based on a scheduled injury to her left upper extremity at the level of the shoulder. Respondent further asks for reimbursement for benefits paid to claimant in connection with her cervical spine.

Claimant argues she proved a work-related injury to her cervical spine as well as her left upper extremity. Claimant asks for an award of 29 percent to her body as a whole and a work disability of 96.5 percent.

The issues for the Board's review are:

1. What is the nature and extent of claimant's disability?

2. Is respondent entitled to reimbursement for benefits paid to claimant in connection with her cervical spine?

FINDINGS OF FACT

Claimant worked for respondent as a dish room trainer at the Cracker Barrel Restaurant in Junction City, Kansas. On October 27, 2007, claimant lifted a full bus tub off a shelf. The tub was heavier than she thought, and her shoulder and neck were "yanked" down.[1] Claimant started having pain in her left shoulder that day. She had never had an injury to her left shoulder before this accident. Claimant continued to work, but her coworkers helped her with lifting.

Respondent sent claimant to Dr. William Jones, a board certified orthopedic surgeon, for treatment. Dr. Jones initially examined claimant on November 16, 2007. He took a complete history and performed a physical examination. Claimant's primary complaint was left shoulder pain. Dr. Jones initially diagnosed claimant with subacromial bursitis and rotator cuff tendonitis. As she failed to improve, Dr. Jones ordered an MRI, which showed a partial tear of the rotator cuff tendon. Dr. Jones performed surgery on claimant's left shoulder on April 28, 2008, which consisted of an open subacromial decompression, biceps tenodesis and rotator cuff repair. He continued to follow up with claimant, and he released her as being at maximum medical improvement (MMI) on December 3, 2008.

At claimant's appointment with Dr. Jones on November 16, 2007, she complained of having occasional paresthesias in the fingers of her left hand. On November 23, 2007, she called Dr. Jones' office complaining that her left arm felt "twingey," at times going down to her elbow.[2] On March 20, 2008, claimant told Dr. Jones she had occasional paresthesias in the fingers of the left hand; Dr. Jones noted the paresthesias appeared to be nonspecific because it followed no dermatomal pattern. Claimant saw Dr. Jones several times after the April 28, 2008, surgery until he released her in December 2008. At no time after the surgery did claimant complain of paresthesias, numbness or tingling.

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[1] Flaitz Depo. (Aug. 20, 2010) at 10.

[2] Williams Depo. at 56.

Claimant did not complain to Dr. Jones about neck pain from her initial visit on November 16, 2007, through December 3, 2008. Dr. Jones said neck pain following a shoulder injury is not uncommon, but claimant made no complaints of neck pain.

On May 6, 2009, claimant returned to Dr. Jones complaining of increased left shoulder pain and right elbow pain. Claimant said the onset of the pain was about a month earlier, and she claimed she had no specific injury. She specifically told Dr. Jones she had no paresthesias. Most of claimant's right elbow pain was over the lateral aspect, and she had shooting pain up into her neck and down into her hand. Dr. Jones diagnosed claimant with probable overuse of her right elbow and overuse pain in her left shoulder, stating that claimant's complaint about right elbow pain was different than pain that begins in the neck from the cervical spine and radiates down the arm. Claimant specifically indicated the pain originated in her right elbow. Dr. Jones said claimant described referral pain from one side to another. Claimant called Dr. Jones a couple times after May 6, 2009, complaining of pain and swelling in her right elbow. In September 2009, claimant called Dr. Jones' office and said she was moving to Ohio. Dr. Jones has not seen claimant since May 6, 2009.

Using the AMA *Guides*,[3] Dr. Jones rated claimant as having an 18 percent permanent partial impairment of the left upper extremity at the level of the shoulder, which would convert to an 11 percent impairment to the whole body. Dr. Jones said the AMA *Guides* does not address rotator cuff injuries, so he used the spirit of the *Guides* to help determine his rating. If he had used only range of motion, the rating would have been less, but he took into account the damage to the superior rotator cuff area and damage to the biceps tendon and combined them to come up with his rating.

In response to an inquiry from respondent's attorney, Dr. Jones authored a letter on December 6, 2010, wherein he stated:

> On multiple evaluations following operative intervention, including specific questioning, she [claimant] denied radicular pain, neck pain or paresthesias involving the left upper extremity. Her mechanism of injury was consistent with a shoulder injury. At no time did she mention neck pain either at the time of the injury or thereafter.[4]

After moving to Ohio, claimant returned to work for respondent at a Cracker Barrel restaurant in Rootstown, Ohio. Claimant went to the emergency room on March 13, 2010, complaining of left-sided neck and shoulder pain that radiated down the left arm. She had no numbness or tingling. Claimant said she had no new injury or trauma since the October 2007 accident. Claimant returned to the emergency room on April 24, 2010, this time

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[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[4] Jones Depo., Ex. 3.

complaining only of left neck pain. She made one more visit to the emergency room in May 2010, at which time claimant said she was in so much pain it was thought she might be having heart palpitations. Claimant said it was around this time that her employer in Ohio told her not to come back to work until she got her shoulder fixed.

Respondent transferred claimant's care from Dr. Jones to Dr. James Lundeen of Plymouth, Ohio. Claimant saw Dr. Lundeen on one occasion, April 27, 2010. Claimant told Dr. Lundeen she had pain from her left shoulder to her elbow with some tingling in her left hand. Dr. Lundeen performed a physical examination and noted that based on the AMA *Guides*, claimant had a 46 percent impairment to the left upper extremity, which equaled a 28 percent impairment to the whole body. Dr. Lundeen also gave claimant a 3 percent impairment to her whole body for pain, which, combined with her 28 percent impairment, totaled a whole body impairment of 31 percent. Claimant only saw Dr. Lundeen one time.

On May 17, 2010, claimant was seen by Dr. Tom Bartsokas. Claimant gave Dr. Bartsokas a history of the accident with onset of severe pain in the left shoulder. She said her symptoms included pain that started at the base of the neck on the left with radiation of tingling as far down as the left elbow. Claimant saw Dr. Bartsokas a couple more times, but he released her to unrestricted full time work on August 2, 2010, telling her since respondent would not authorize treatment, he had nothing to offer her.

Claimant saw Dr. Philip Stickney on September 27, 2010. Claimant described a history of piercing, achy pain in her left arm and neck going down the arm but not involving the left pinkie, which began when lifting a heavy bussing box with dishes. He tested her cervical spine range of motion and found her flexion was full, but created end point pain and worsened her paresthesias; her extension was full with decreased pain and paresthesias; her right and left lateral rotation was full and did not affect her paresthesias. He ordered an MRI of her lumbar spine, which showed multiple degenerative discs, moderate canal stenosis at C5, and stenosis centrally at C6. Dr. Stickney referred claimant to Dr. Joel Siegal.

Claimant saw Dr. Siegal on November 18, 2010. He reviewed the September 2010 MRI and performed a physical examination, after which he recommended claimant have a C5 and C6 anterior cervical spine decompression and fusion. Dr. Siegal wrote Dr. Bartsokas on November 23, 2010, in which he stated in part:

> We do feel that because she described her history, no neck pain or arm discomfort prior to her work related injury three years ago, that this problem is indeed referable to that event after which she developed the neck and arm symptoms.[5]

[5] P.H. Trans. (Jan. 26, 2011), Cl. Ex. 1 at 1.

Dr. Terrence Pratt is board certified in physical medicine and rehabilitation. He evaluated claimant on April 15, 2011, at the request of the ALJ, to give an opinion on what injury or injuries claimant sustained as a direct result of her work-related accident; whether her current complaints were causally related to the injury of October 27, 2007; what additional treatment claimant needed as a result of her injury or injuries; and what restrictions she might need.

Claimant gave Dr. Pratt a history of her accident. She complained of continuous symptoms of numbness on the left side of her face, tingling of her fingers, and pain in her cervical region on the left. She noted discomfort from her face to her hand on the left and weakness of her left upper extremity. Claimant denied problems in her left upper extremity or cervical areas before the October 2007 accident.

Dr. Pratt reviewed claimant's medical records, MRIs and x-ray films. He performed a physical examination, after which he diagnosed claimant with left rotator cuff tear with impingement status, post arthroscopic left shoulder procedure with open subacromial decompression, rotator cuff repair and biceps tenodesis, and cervicothoracic syndrome with C5-6 spinal stenosis and C6-7 left disc protrusion and spondylosis.

Dr. Pratt opined that claimant suffered an injury to her left shoulder. At the time claimant presented to Dr. Jones, she had symptoms radiating to her elbow and paresthesias of her fingers, but she did not report cervical involvement until May 2009. Dr. Pratt stated it was more probable than not that claimant aggravated a preexisting cervical condition in the 2007 event. Dr. Pratt has not issued an opinion as to whether the October 27, 2007, aggravation was permanent or temporary.

In his report, Dr. Pratt opined:

> She [claimant] did have symptoms which could suggest radiculopathy from the cervical region at the time of her initial visit to Dr. Jones but I did not see any indication of an examination of the cervical region in the records that were available at that time. It does appear at some point that there was a change in her symptoms and much more significant involvement. That was some time prior to the May 6, 2009 visit. . . .
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> . . . I do believe that in part her current complaints relate to the 2007 event, and at some point, there was a change in symptoms with aggravation apparently of underlying involvement resulting in more significant symptoms. The information is unclear to a reasonable degree of medical certainty whether a subsequent event occurred. It is clear that [the] more diffuse symptoms that she complains of today were not present at the time of her 2007 event.[6]

[6] Pratt Depo., Ex. 2 at 5.

Dr. Pratt said claimant's degenerative changes identified in the September 2010 MRI were, to a reasonable degree of medical certainty, present before the 2007 event with potential for aggravation in the work related accident, but were not as significant as her symptoms noted on May 6, 2009. Dr. Pratt believes that shortly before May 2009, a significant aggravation of claimant's cervical condition occurred causing an increase in symptoms as compared to what existed after the October 27, 2007, incident. Dr. Pratt, however, could not say within a reasonable degree of medical certainty that claimant had a subsequent or intervening accident in 2009.

Dr. Michael Kellis is board certified in family medicine and in sports medicine. He practices in the State of Ohio and is familiar with the fourth edition of the AMA *Guides*. At the request of the claimant's attorney, Dr. Kellis performed an independent medical examination of claimant on December 5, 2011. Dr. Kellis reviewed the medical records and surgical reports of Dr. Siegal. Dr. Siegal had diagnosed claimant with herniated cervical disks with left-sided radiculopathy and had performed an anterior cervical body fusion and an LDR cage to stabilize the spine in August 2011. Dr. Kellis admitted he did not have records from claimant's other treating physicians at the time of his examination and that it would be important to have all the medical records in order to render a full, appropriate and thorough opinion.

Claimant gave Dr. Kellis a history of lifting a tray of plates that was heavier than expected. She said the left side of her body jerked downward and she felt a pop on the left side of her neck. Based primarily on claimant's verbal history, Dr. Kellis opined that there was a causal relationship between claimant's trauma and her work injury.

Using the AMA *Guides*, Dr. Kellis opined that claimant had a 20 percent whole body impairment from claimant's cervical spine injury. He rated claimant as having an 18 percent impairment to the left upper extremity, which converted to an 11 percent disability to the whole body.[7] The 20 percent cervical impairment and the 11 percent shoulder impairment combined for an overall impairment of 29 percent to the whole body.

Dr. Kellis recommended claimant have permanent work restrictions of no lifting greater than 10 pounds; no pushing or pulling; and flexion, extension and twisting of the neck must be limited. Dr. Kellis reviewed the task list prepared by Dr. Robert Barnett.[8] Of the 15 tasks on the list, Dr. Kellis opined claimant was unable to perform 14 for a 93 percent task loss. Further, Dr. Kellis recommended claimant have additional medical

[7] Dr. Kellis said his 11 percent whole person impairment for claimant's left shoulder was based in large part on the report of Dr. Jones.

[8] Dr. Robert Barnett is a clinical psychologist and a rehabilitation counselor. At the request of claimant's attorney, he interviewed claimant by telephone on December 15, 2011, after which he prepared a list of 15 unduplicated tasks claimant had performed in the 15-year period before October 27, 2007.

treatment. Specifically he recommended she have additional physical therapy. He also believed she would need pain medication in the future.

Dr. James Zarr is a specialist in physical medicine and rehabilitation. He evaluated claimant at the request of respondent on April 27, 2012. Claimant gave him a history of lifting a tub full of dishes and developing a sudden onset of shoulder and arm pain. After reviewing the medical records and history given by claimant, Dr. Zarr performed a physical examination, after which he diagnosed claimant with persistent neck and left shoulder pain. Dr. Zarr found claimant had reached MMI for both her neck and shoulder conditions. Dr. Zarr believed the lifting incident of October 27, 2007, caused claimant's left shoulder condition. However, he did not believe the incident of October 27, 2007, caused claimant's neck condition. To support his opinion, Dr. Zarr cited the two-year delay in complaints and the MRI findings, which he said were more consistent with chronic degenerative condition than an acute injury. Dr. Zarr testified he could state within a reasonable probability that stenosis was present in claimant's spine prior to October 27, 2007. He did not believe that the work injury aggravated, accelerated or intensified the stenosis. Dr. Zarr said if the stenosis was the cause of her neck pain, she should have gotten better after surgery, but she did not. It is Dr. Zarr's best guess that the cause of claimant's neck pain is muscular soft tissue.

Dr. Zarr rated claimant as having a 5 percent permanent partial impairment of her left upper extremity at the level of the shoulder. With regard to claimant's neck, Dr. Zarr rated her impairment as being 25 percent of the whole body.

Dr. Zarr believes someone who has had a cervical fusion with plating should not lift more than 50 pounds. Dr. Zarr reviewed the task list prepared by Dick Santner.[9] He opined that claimant would be able to perform all 16 tasks on Mr. Santner's list.

PRINCIPLES OF LAW

K.S.A. 2007 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends." K.S.A. 2007 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

[9] Dick Santner, a vocational rehabilitation counselor, interviewed claimant at the request of respondent on July 18, 2012, and followed up with a telephone interview on September 20, 2012. He compiled a list of 16 unduplicated tasks that claimant performed in the 15-year period prior to her work-related accident.

ANALYSIS

1. Nature and Extent of Impairment

The Board does not agree with the ALJ that claimant suffers from a cervical spine condition as the result of her October 27, 2007, injury. The ALJ relied upon the testimony of Dr. Jones and Dr. Pratt to arrive at the conclusion that claimant suffers from a cervical spine condition related to her work injury. The Board finds the ALJ's logic flawed. Dr. Jones treated and rated only the shoulder. Dr. Jones testified that claimant had no neck pain or radicular symptoms during his treatment. Upon review of the medical records and testimony of Dr. Jones, the Board finds that the evidence is insufficient to conclude that claimant's October 2007 accidental injury caused or aggravated her cervical spine problems.

The same is true with Dr. Pratt. Initially, Dr. Pratt wrote in his April 15, 2011, report that he found the cervical spine to be related to the claimant's work-related injury. However, Dr. Pratt did not support his written causation opinion when he testified. Dr. Pratt testified that, while claimant may have had a temporary aggravation of her cervical spine related to the 2007 incident, something happened in 2009 that was more significant.[10] Dr. Pratt agreed he had no opinion regarding whether the 2007 aggravation was temporary or permanent. When comparing the cervical spine symptoms relating to the 2007 accident and whatever occurred in 2009, Dr. Pratt stated that "there were persistent symptoms" after 2009.[11] Dr. Pratt's testimony is more consistent with an aggravation occurring in 2009 than from the 2007 work-related injury.

In arriving at a whole body impairment, the ALJ combined Dr. Jones' shoulder rating and Dr. Zarr's whole body impairment. Dr. Zarr assessed a 25 percent DRE Category IV impairment based upon the AMA *Guides* for claimant's cervical spine condition. In his report, Dr. Zarr stated: "I do not feel that the neck complaints are causally related to the work injury of 10/27/07."[12] When ask to explain his opinion, Dr. Zarr testified: "There was a two-year delay in complaints and the MRI findings were more consistent with a chronic degenerative condition rather than an acute injury."[13]

In her analysis, the ALJ did not include the opinions of Dr. Kellis on causation and impairment. The ALJ did not comment on the credibility of Dr. Kellis or why his opinions were given little weight. The Board finds that Dr. Kellis' opinion regarding causation should

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[10] Pratt Depo. at 23.

[11] *Id.* at 26.

[12] Zarr Depo., Ex. 2.

[13] Zarr Depo. at 9-10.

be given no weight due to the fact that he had no medical records prior to 2009 and solely relied upon the oral representation of the history provided by claimant.

Dr. Jones, the authorized treating physician, assessed an 18 percent impairment to claimant's left shoulder. Dr. Kellis also assessed an 18 percent impairment to the left shoulder. Dr. Lundeen, whose report was admitted into the record, assessed a 46 percent impairment for the left shoulder. Dr. Zarr assessed a 5 percent impairment to the left shoulder. The Board find the opinions of Dr. Kellis and Dr. Jones to be persuasive and finds claimant suffers an 18 percent impairment of the left shoulder.

2. Overpayment of benefits

Respondent asks for reimbursement for temporary total disability benefits paid to claimant in connection with her cervical spine. Respondent paid $12,170.12 temporary total disability benefits and $37,624.67 in medical expenses related to claimant's cervical spine condition. The Board finds these amounts to be an overpayment. Respondent may seek reimbursement pursuant to K.S.A. 44-534a(b.)

CONCLUSION

Based upon the foregoing, the Board finds that claimant sustained an 18 percent impairment of the left upper extremity at the level of the shoulder. All medical and temporary total disability payments made by respondent for treatment of claimant's cervical spine are found to be an overpayment. The overpayment of temporary total disability benefits related to claimant's cervical spine condition shall not act as a credit against this award.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca A. Sanders dated December 27, 2012, is modified to reflect the above findings.

Claimant is entitled to 24.38 weeks of temporary total disability compensation at the rate of $173.86 per week in the amount of $4,238.71 followed by 36.11 weeks of permanent partial disability compensation, at the rate of $173.86 per week, in the amount of $6,278.08 for an 18 percent loss of use of the left shoulder, making a total award of $10,516.79.

IT IS SO ORDERED.

Dated this _____ day of May, 2013.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

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